PRINTED: 04/07/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185166	A. BUILDING _____ B. WING _____	03/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARLAN HEALTH & REHABILITATION CENTER	200 MEDICAL CENTER DRIVE HARLAN, KY 40831

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey (KY16066) was initiated and concluded on March 24, 2011. The allegation was unsubstantiated but deficient practice was identified at 'D' level.	F 000		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services to prevent the development of a pressure ulcer for one of three sampled residents. Resident #3 developed a Stage 2 pressure ulcer that was not reported or documented by the State Registered Nurse Aide. The findings include: A review of the facility's policy/procedure related to Skin Ulcers (no date) revealed upon admission or readmission to the facility all residents shall receive a head-to-toe assessment for identification of any skin conditions. After the initial assessment, at least one time a week the resident shall be reassessed utilizing the Skin Integrity Assessment. All unusual skin conditions	F 314		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Doris Pace	Administrator	4/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 314	Continued From page 1 will be noted. Any skin irregularity identified by the State Registered Nurse Aide (SRNA) shall be verified by the licensed nurse and documented in the nurse's notes. The physician will be notified of any pressure sores or skin conditions and dressing orders and treatment plans will be under the direction of the attending physician. A review of the medical record revealed resident #3 was admitted to the facility on June 16, 2009, with diagnoses that included Atrial Fibrillation, Anxiety, Neuropathy of Bilateral Hands, Gout, Cerebral Vascular Accident, Hypertension, Insomnia, Hypertension, Left Tibia Fracture, and Status Post Motor Vehicle Accident. Review of the Minimum Data Set dated March 17, 2011, revealed resident #3 had no pressure ulcers on prior assessment, was at risk for pressure sores, and had been assessed to require skin and ulcer treatments. Review of the Care Plan for resident #3 revealed the resident was to be turned and repositioned every two hours and staff was required to implement measures to maintain healthy intact skin and observe for skin breakdown every shift. The Care Plan further revealed that resident #3 was to be provided with peri-care, skin assessments weekly, and staff was required to ensure the resident's skin was thoroughly dry after bathing. Observation of resident #3 upon initial tour on March 24, 2011, at 10:30 a.m., revealed the resident was on the right side sleeping, with side rails elevated, call bell within reach, and water at the bedside. The resident's room was observed to be clean with no odors noted.	F 314		

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F 314	Continued From page 2 Observation of resident #3 on March 24, 2011, at 2:40 p.m., revealed the resident was in the supine position with the call bell within reach and water at the bedside. A foam mattress was observed on resident #3's bed for pressure reduction. The resident stated the aides came to the room to reposition the resident and change the resident's briefs every two hours. A skin assessment was conducted for resident #3 on March 24, 2011, at 3:00 p.m., which revealed an open area in the resident's skin to the left buttock. Interview on March 24, 2011, at 3:10 p.m., with the SRNA responsible for caring for resident #3 on this date revealed resident #3 was checked on, repositioned, and changed every two hours. The aide stated if there was a new area in the resident's skin the SRNA was required to report the area to the nurse. The SRNA stated she had observed the open area to the resident's skin earlier in the shift on March 24, 2011, but failed to report the open area to the nurse or document the area on the SRNA care plan. Interview with Licensed Practical Nurse during the skin assessment on March 24, 2011, at 3:00 p.m., revealed the open area had not been previously documented or verbally reported. Interview with the Administrator and Registered Nurse/Consultant Quality Inspector on March 24, 2011, at 3:30 p.m., concluded that the SRNA should be informing the nurse of skin changes and there should be documentation on the resident's record of the changes.	F 314		

Harlan Health & Rehabilitation Center
Abbreviated Survey—March 24, 2011
Plan of Correction

F 314

1.) Resident #3 was assessed by nursing staff on 3/24/11 and was observed to have no further breakdown. The MD and responsible party were notified and appropriate treatment was initiated immediately.

2.) A head to toe skin assessment was performed on all residents to ensure that any skin breakdown was identified and treated appropriately.

3.) An in-service was conducted by the Director of Nursing and nursing administrative staff beginning on 3/24/11 with all nurse aides and nurses. The in-service addressed the importance of nurse aides reporting changes in skin integrity immediately to the nurse, and the importance of observing each resident's skin daily for changes. In addition, the nurses were in-serviced on assessing skin conditions, reporting skin alterations to the MD and Responsible Party immediately, providing appropriate treatment and updating the nurse aide Kardex with changes in skin conditions as indicated.

4.) The CQI committee designee will conduct two residents' skin assessments on a weekly basis for one month then four skin assessments per month for one quarter. These audits will be done through direct resident observation and chart review to ensure that alterations in skin integrity are assessed, treated, and documented appropriately. Any identified irregularities will be corrected immediately and reported to the CQI committee for further action.

5.) Completion Date: 4/1/11